State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in quadruplicate (type, if possible). Mail original and one copy to:

STATE COMPENSATION INSURANCE FUND

P.O. BOX 659011, SACRAMENTO, CA 95865-9011
ALSO SEND ONE COPY TO: OFFICE OF EMERGENCY SERVICES - DSW PROGRAM
3650 SCHRIEVER AVENUE, MATHER, CA 95655
BOTH SIDES OF THIS FORM MUST BE COMPLETED.

OSHA Case No.

DR _____

☐ Fatality

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident ***OR*** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported **immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

COUNCIL

1. LOCAL ACCREDITED DISASTER COUNCIL
1A. POLICY NUMBER
DO NOT USE THIS COLUMN

2. MAILING ADDRESS (Number and Street, City, ZIP)
2A. PHONE NUMBER
Case No.

3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)
3A. LOCATION CODE
Ownership

4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.
DISASTER SERVICES
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
Industry

6. TYPE OF EMPLOYER
☐ PRIVATE ☐ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☒ OTHER GOVERNMENT - SPECIFY **DISASTER COUNCIL**
Occupation

DISASTER WORKER

7. WORKER'S NAME
8. SOCIAL SECURITY NUMBER
9. DATE OF BIRTH (mm/dd/yy)
Sex

10. HOME ADDRESS (Number and Street, City, ZIP)
10A. PHONE NUMBER
Age

11. SEX ☐ MALE ☐ FEMALE
12. OCCUPATION (Regular job title–No initials, abbreviations or numbers)
13. DATE OF HIRE (mm/dd/yy)
Daily hours

14. WORKER USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours
14A. EMPLOYMENT STATUS (Check applicable status at time of injury.) ___regular full-time ___part-time ___temporary ___seasonal ___unemployed ___on strike ___disabled ___retired ___laid off ___other
14B.
Days per week

15.
16.
Weekly hours

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)
18. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.
19. TIME WORKER BEGAN WORK _____ A.M. _____ P.M.
20. IF WORKER DIED, DATE OF DEATH (mm/dd/yy)
Weekly wage

21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
22. DATE LAST WORKED (mm/dd/yy)
23. DATE RETURNED TO WORK (mm/dd/yy)
24. IF STILL OFF WORK, CHECK THIS BOX ☐
County

25.
26.
27. DATE OF COUNCIL'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)
28. DATE WORKER WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)
Nature of injury

29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.
Part of body

30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, ZIP Code)
30A. COUNTY
30B. ON COUNCIL'S PREMISES? ☐ YES ☐ NO
Source

31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.
32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO
Event

33. EQUIPMENT, MATERIALS AND CHEMICALS THE WORKER WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.
Sec. Source

34. SPECIFIC ACTIVITY THE WORKER WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.
Extent of Injury

35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.

36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
36A. PHONE NUMBER

37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
37A. PHONE NUMBER

38. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☐ NO IF YES, GIVE DETAILS ON REVERSE SIDE.

39. NAME AND ADDRESS OF PRESENT EMPLOYER

Completed by (type or print)	Signature	Title	Date

SCIF 3267 (REV. 12-00)

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE WORKING DAY OF YOUR KNOWLEDGE OF OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTS IN LOST TIME OR MEDICAL TREATMENT.

40. OCCUPATION (REGULAR JOB TITLE, NOT SPECIFIC ACTIVITY AT TIME OF INJURY)

41. WAS WORKER REGISTERED WITH A LOCAL ACCREDITED DISASTER COUNCIL? IF SO, WHICH _____

42. DID INJURY ARISE OUT OF ACTIVITIES AS A DISASTER SERVICE WORKER? _____